an approach, physicians become tempered by an awareness of the self-assurance of true reality, worthy of a mature physician.

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Trends in Obstetrics

TO THE EDITOR: My long-time friend and colleague, Peter Hughes, was in a foul mood the other morning. "I'm going to quit doing OB," he grumbled over his midmorning cup of coffee. "It just isn't fun anymore. It's becoming mechanized and dehumanized. Added to that, there is the ever present threat of malpractice that makes me uncomfortable."

"It used to be that the attending physician was the captain of the ship in the OB department," continued friend Peter. "But now our importance is diluted by the OB nurse who hooks our OB patient to the fetal monitor almost as soon as she walks through the door. And then she may proceed to invade the uterine cavity as she screws an electrode into the baby's scalp, or shoves up an intrauterine catheter. Just let the squiggles on the fetal monitor tape get a little erratic, and she begins to look at me cross-eyed for not rushing the patient in for a cesarean section. I've had it. I'm quitting."

Are not these typical of the comments we have been hearing lately from colleagues who are getting ready to throw in their accoucheur's sponge, or preparing to put away their axis-traction forceps, their DeLee fetus scopes? They say "Let those young fellows take over with their fetal monitors, their repeated amniocenteses, their cesarean sections done at the drop of a late deceleration."

Yet there are some of us who hate the thought of giving up OB. We know the sheer joy of bringing a new life into the world, of hearing that first cry, of seeing that exultant look of happiness on the new mother's face.

We do have our moments of doubt. At times we wonder, as we try so hard to exercise patient nonintervention we were taught was the essence of obstetrical art, whether those old fundamental teachings are really worth clinging to when, indeed, it seems that obstetric aggressiveness is the order of the day.

There was a time, for example, when delivering a baby by cesarean section was an admission of defeat—for the mother as well as the physician. A day when we strove to develop our skill with forceps, and when the ability to deliver a difficult breech was looked upon as a worthy accomplishment. In that day maternal morbidity and mortality was the prime consideration.

Now we are in a period of rapid change. Obstetrics is becoming less of an art and more of a science. The availability of fetal monitoring; oxytocin challenge tests; laboratory evaluations of serum estriols, bilirubin and palmitic acid, and L/S ratios suggests that mechanical devices and esoteric scientific data are threatening to replace good old-fashioned clinical judgment.

Moreover, the rights of the fetus are now being equated with those of the mother. Sophisticated (and expensive) neonatal intensive care units and the rapidly rising star of the neonatologist bear witness to that.

We are sorry that friend Peter, and others like him, are deserting the ranks. Now those of us who intend to stay in this happy business of bringing babies into the world must accept the increased responsibility of applying the new technologies judiciously and appropriately. After all, it's still the attending physician, not the nurse or the electronic machine, who must make the judgment call. To do this wisely and well we may have to unlearn some of the old obstetrical dictums, reevaluate some of our practices and stay abreast of new developments.

We need to urge senior staffers like Pete to stick around long enough to temper the boundless enthusiasm for medical gadgets and invasive obstetrics—at least until the final answers are in.

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President Lincoln's Illness

TO THE EDITOR: The diagnosis of Marfan syndrome for President Lincoln [Schwartz H: Abraham Lincoln and cardiac decompensation—A preliminary report. West J Med 128:174-177, Feb 1978] seems very doubtful to me.

Few Presidents had such extensive life examinations made as President Lincoln; because of his features he was sculpted more than any of the other Presidents, he was congenial and consenting to the artists, and they recorded even finite matters about the President. One woman sculptor, the precocious Miss Vinnie Ream, made several plaster bas reliefs and busts of Lincoln in 1864, and he sat for her numerous times; Congress commissioned her to do a full length Lincoln for the Capitol, paying her the unusual sum at the time of $10,000.00, much to the disgust and anguish of Mrs. Mary Lincoln, the President's widow. None of her observations confirmed or pointed to the eye or skeletal deformities.

The most famous sculptor of Lincoln was Leonard Wells Volk, who made a life mask of Lincoln in 1860. To save him a number of sittings, Volk took a plaster cast of his face, a painful process that Lincoln submitted to with characteristic good humor, although it made his eyes water and pulled out hairs when it was removed. Volk made his famous life-sized plaster statue for the Illinois State Capitol from the life mask, and a painting of Lincoln, and the famous casts of Lincoln's hands done in 1860 after the inauguration.

Lincoln was a practicing lawyer working on a major law case in Chicago at the time of the face cast, and no reference was made to the eye difficulties present in 50 percent of patients with Marfan syndrome. It is hard to conceive that the popular President had any eye problems that he could or would conceal. Indeed he often dwelled on his disabilities as in his talks with Attorney General Speed.

In no place can one find reference to bony deformities of the chest or bones. During one sitting Volk referred to his breast and brawny shoulders, and made Lincoln peel down his underwear so that he could show them as "nature presented them," which seemed great although large.

Most famous were the casts of Lincoln's hands made by Volk in 1860 in Springfield, Illinois. The right hand was swollen, probably from greeting well-wishers following his nomination two days earlier. Volk suggested that Lincoln grasp something while the cast was being taken, and the candidate left the parlor for the woodshed to saw off a piece of broom handle; when he returned he was trimming the piece with his pocket knife, stating that he wished to have it look nice. These are big, strong hands; not the hyperextendable weak hands seen in Marfan syndrome.

Except for his unusual height of 6′4″, there seem to be absolutely no eye or skeletal indications that Lincoln had Marfan syndrome.

I do believe that Lincoln had aortic insufficiency, as described by Dr. Schwartz. Contrary to Dr. Schwartz's feeling that Lincoln had no emotional distress while President, another Lincoln sculptor (Thomas Dow Jones) noted that Lincoln became very melancholy as his first inauguration drew near, transforming his face to an iron mask, which Lincoln said "looked like the critter."

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Registered Nurses and Long-Term Care

TO THE EDITOR: A major deficiency in the provision of health care today is the failure of physicians to fulfill their responsibilities toward chronically ill patients in nursing homes. This group constitutes one of the largest and most costly segments of the health care system in this country. Attempts to involve physicians more effectively have been almost universally unsuccessful. A fundamental change is needed.

It is proposed that the function of registered nurses (RN) in skilled nursing facilities (SNF) be altered radically, and the status of physicians in SNF be changed completely. In substance, it is suggested that primary responsibility for *continuing* direct patient care be placed on the registered nurse in charge of the SNF, retaining a physician solely as consultant to the RN when requested.

It is obvious that the responsibility of the physician toward chronically ill patients should not differ from his or her responsibility to acutely ill patients. It is well documented that such responsibility has failed in nursing homes, with few notable exceptions. Increasing regulations have been imposed on long-term care facilities over the past decade or more to cope with difficulties stemming from failure of physician involvement as presently operative. The most recent symptomatic remedy has been the requirement that a medical director be retained in each facility certified for the Medicare program.